GUIDELINES FOR HIV COUNSELING AND TESTING OF EMANCIPATED MINORS AND MINORS SEEKING TESTING WITHOUT PARENTAL CONSENT

Adolescents are best served in a setting that permits continuity of care. Therefore, it is recommended that adolescents are tested confidentially, rather than anonymously as they would be at anonymous testing sites. However, by virtue of their right to consent to anonymous testing, adolescents may not be denied access to anonymous testing.

When HIV testing is indicated, based on risk behaviors of an adolescent, clinical criteria, or an appropriate request by an adolescent, it should be conducted in easily accessible settings where pre- and post-test counseling that is sensitive, developmentally, culturally and linguistically appropriate is available. Appropriate referrals to follow-up mental health and medical care must be made and providers must insure that adolescents are linked with these referrals.

Adolescents should be helped to identify a supportive parent or other adult in the testing procedure and in follow-up care. If this person cannot be identified by the adolescent, the agency will identify an appropriate provider.

" Adolescent HIV Antibody Counseling and Testing Policy"
Massachusetts Department of Public Health

New Rhode Island legislation permits HIV testing of minors without parental consent. As a consequence, organizations and professionals providing counseling and testing for HIV infection may be seeing an increased number of clients who are under age 18, and unaccompanied by parent or guardian. These guidelines have been developed to help you adapt counseling and testing protocols, where necessary, to the special needs of this population.

The basic goals of HIV counseling and testing are the same for adolescents as for adults:

(1) Sensitivity and supportiveness in working with clients.

(2) Explanation and protection of client rights regarding informed consent and disclosure.

(3) Education and counseling directed to risk assessment, risk reduction, and prevention.

(4) Determination of HIV status and explanation of test results to the client.

(5) Referral to health and social service providers, as necessary, and appropriate follow-up on referrals.

The way in which these goals are pursued will have to be adjusted to special characteristics of adolescent perception, behavior, and social relations. For example:

(1) Adolescents may be prone to risk-taking, either through a "sense of invulnerability " or as a function of depression and low self-esteem.

(2) Adolescent may have a strong capacity for denial, be "present time oriented" (i.e., have little concern for future consequences), or resistant to advice from adults which is viewed as impinging on their privacy or autonomy.

(3) Adolescents may be especially isolated, i.e., be without effective social support systems such as close family members, trusted adult friends, or responsible peers.

Special efforts must be made to provide understanding and support for these adolescents.

RECOMMENDATIONS

Organizations and professionals offering HIV counseling and testing to emancipated minors, or minors seeking testing without parental consent, should:

A. Pretest Counseling

(1) Treat adolescents as they would adult clients, i.e., supportively, non-judgmentally, and with respect for their personal autonomy.

(2) Inform adolescents of their right to testing without parental consent, but encourage them to involve parents in their social support network.

(3) Inform adolescents that anonymous testing is available. Explain the difference between anonymous and confidential testing but urge them to be counseled and tested in confidential settings to facilitate: (a) continuity of care if HIV positive, and (b) testing and treatment for related disease, such as STDs.

(4) To the extent possible, schedule adolescents for different times and/or waiting rooms than adults, and provide reading materials of interest to adolescents in the waiting area.

(5) Allow more time for adolescent visits than for the usual adult visit, because counselors/adolescents may need extra time for explanation and assessment.

(6) Be prepared to offer adolescent clients more than one counseling visit before the client decides to be tested.

(7) Be aware that establishing trust between client and counselor is even more important with adolescents than with adult client. For adolescents, trust may be a precondition for successful counseling.

(8) Explain everything in simple language, probe to make sure the client understands, and encourage questions. Teaching aids, such as illustrated workbooks, should be available.

(9) Make special efforts to assure that counseling is culturally sensitive and language specific, e.g., with regard to minorities, new immigrants, street culture, etc. This requirement takes on special meaning in dealing with clients who are also part of an adolescent subculture, to which the counselor must be able to relate effectively.

(10) Be prepared to help the adolescent client do things, which adult clients usually do without assistance, such as completing a risk-assessment questionnaire.

(11) Ascertain availability to adolescent clients of social support systems to help them cope emotionally with counseling issues and test results, e.g. , supportive parent or other adult, community health or social service worker, responsible peers.

Availability must include clear willingness of the adolescent client to involve his/her support system in HIV testing concerns.

If an adolescent client has no social support system, counselors must be prepared to identify an alternative individual or organization, competent and willing to perform this function on a continuing basis.

(12) Be prepared to offer comprehensive services, or referral to comprehensive services which may be needed by adolescent clients, which bear on risks of HIV transmission or need for treatment of HIV infection, including health care, long-term counseling, drug treatment, residential services, etc.

(13) Be alert to the relative risks (e. g., potential for violence or suicide) and benefits of HIV testing for adolescent clients; be prepared to postpone testing when risks exceed benefits, and schedule a follow-up visit for further discussion and assessment.

B. Post-Test Counseling:

(14) Whether the client is positive or negative, the counselor should review the means of transmitting HIV infection and methods to prevent transmission.

(15) Whether the client is positive or negative, the counselor should provide teen-specific reference materials to take home, including printed AIDS prevention information and a list of community-based resource agencies. (See Appendix)

(16) If the client is HIV negative, the counselor should discuss the appropriateness of periodic retesting. If the counselor believes that the client is at high risk for HIV infection, an appointment should be made for the next counseling and testing visit. Under any circumstances, the counselor should encourage the client to get in touch if he/she needs information or assistance.

(17) When the counselor plans to see an HIV positive client, he/she should make arrangements in advance with a health care provider to give the client prompt medical attention. If the client agrees, the counselor should call the provider to confirm the appointment and, if feasible and appropriate, should accompany the client to the health care setting, and introduce him/her to the provider.

(18) If the client is HIV positive, the counselor also want to make an appointment for the client with an appropriate social service agency for comprehensive case management.

In some cases the counselor may want to make similar arrangements for an HIV negative client whose life conditions are threatening to physical and emotional health.

(19) The counselor should make follow-up calls to both health care providers and social service agencies to make sure that HIV positive clients have acted on referrals and are under effective management. If clients have been lost to management, confidential efforts should be made to renew contact and urge clients to obtain treatment and assistance.

(20) Counselors should encourage clients who are HIV positive to tell their parents or other appropriate adults, and secure their support during treatment and case management.

(21) Counselors should encourage HIV positive clients to notify sex or needle-sharing partners that are at risk of HIV infection and those partners have an HIV test. If clients feel that they cannot notify their partners personally, the counselor should suggest using the confidential Partner Notification Program administered by the Rhode Island Department of Health, and/or seek the assistance of his/her case manager.

C. Suspected Child/Sexual Abuse

(22) Rhode Island Law requires that cases of suspected child and/or sexual abuse be reported to the State Department for Children and their Families. (See Appendix.) Counselors are encouraged to take all necessary steps to facilitate reporting.

40-11-3. **Duty to report-Deprivation of nutrition or medical treatment**. – Any person who has reasonable cause to know or suspect that any child has been abused or neglected as defined herein shall, within twenty-four (24) hours, transfer such information to the Department for Children and their Families or its agent who shall cause the report, to be investigated immediately. As a result of such reports and referrals, protective social services shall be made available to such children in an effort to safeguard and enhance the welfare of such children and to provide a means to prevent further abuse or neglect. The said department shall establish and implement a single, statewide, toll-free telephone known to operate twenty-four (24) hours per day, seven (7) days per week for the receipt of reports concerning child abuse and neglect. The department shall establish rules and regulations requiring hospitals, health care centers, emergency room and other appropriate health facilities to report on a quarterly basis information concerning the number of children treated for specific injuries and the number of cases reported by these institutions as suspected child abuse.

Such reporting shall include immediate notification of the department of any instance where parents of an infant have requested deprivation of nutrition that is necessary to sustain life and /or who have requested deprivation of medical or surgical intervention that is necessary to remedy or ameliorate a life threatening medical condition, if the nutrition or medical or surgical intervention is generally provided to similar nutritional, medical or surgical conditioned infants, handicapped or non-handicapped.

Nothing in this section shall be interpreted to prevent a child's parents and physician from discontinuing the use of life-support systems or non-palliative treatment for a child who is terminally ill where, in the opinion of the child's physician exercising competent medical judgment, the child has no reasonable chance of recovery from said terminal illness despite every appropriate medical treatment to correct such condition.

HIV LAW FOR TESTING OF ADOLESCENTS

PUBLIC LAWS OF RHODE ISLAND CHAPRET 90 -169

23-8-1.1 Consent to testing and treatment-Reportable -

Communicable diseases. – Persons under eighteen (18) years of age may give legal consent for testing, examination and/or treatment for any reportable communicable disease.

.